

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - BUILDING #1</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRADLEY HEALTH CARE &amp; REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2910 PEERLESS RD CLEVELAND, TN 37312</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the survey on June 10, 2013, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes	N 002		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1